(SAMPLE MEMO TO EMPLOYEES)

TO: All Department Employees

FROM: Office of the Director

Subject: Resurvey of Employee Disabilities

Under the Rehabilitation Act of 1973 and California Government Code Section 19233, the State Personnel Board requires departments to periodically provide their employees with the opportunity to self-identify their disabilities. Accordingly, I ask your cooperation in completing and returning the attached green State Employee Disability Questionnaire-Resurvey (SPB-131A). The department is firmly committed to the pursuit of equal employment opportunities for all its employees, including those with disabilities.

The data that is collected from the questionnaires will only be used to prepare reports designed to identify areas where discrimination may occur and will help in the development of employment goals and actions to facilitate the employment of persons with disabilities. The information gathered will not be reviewed by a medical officer and will not identify employees individually. The data will be incorporated into the State Controller's Office Employment History Data Base. Every effort will be made to ensure the confidentiality of the information provided.

Note: All information requested on the questionnaire, including your Social Security Number, is requested on a voluntary basis. Your confidentiality is guaranteed in accordance with the Privacy Act of 1974 (PL 93-579). Your Social Security Number is needed to identify you as an employee of the department. If you do not provide your Social Security Number you cannot be counted as an employee of our department with a disability.

Before completing the attached survey questionnaire, please read the instructions carefully. Answer the series of questions that follow by checking the appropriate box "Yes" or "No". Turn the questionnaire over and enter your Social Security Number where indicated in the upper right corner. Locate the appropriate code letter for your disability, circle it, and record it in the upper right hand corner in the space indicated for "Primary Disability Code". If you have more than one disability, you may indicate up to three additional disabilities in the space indicated for "Secondary Disability Codes". Please note that a code of "X" indicates no disability.

After completing the questionnaire, please return it, in a sealed envelope, to the Personnel Office by _____. The questionnaires will then be forwarded on to the State Personnel Board. After the information has been input into the data base,

all questionnaires will be destroyed. If you prefer to mail your disability questionnaire directly to the State Personnel Board, you may do so.

Although completion of the disability questionnaire is voluntary, I want to highly encourage you to complete it accurately and return it. It is very important for the State to have complete and accurate information on the representation of employees with disabilities in order to justify programs and resources needed to facilitate the hiring of persons with disabilities. If you wish to change your status in the future, please contact the personnel office and fill out a white State Employee Disability Questionnaire (SPB-131) form.

If you have any questions about this survey, please contact the Personnel Office at _____. If you have questions concerning the disability identification process, you may contact the State Personnel Board's Civil Rights Programs Unit at (916) 653-1579, CALNET 453-1579 or TDD (916) 653-1498.

Thank you for your cooperation.

Director

Attachments